STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	)))))	FILING COVER SHEET

DOCKET NO. INS-06-900

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Respectfully submitted,

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IN RE: REVIEW OF AGGREGATE)
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HEALTH FOR THE SECOND)
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IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	)))))	BRIEF OF INTERVENOR MAINE STATE CHAMBER OF COMMERCE

DOCKET NO. INS-06-900

Pursuant to the Notice of Hearing dated April 26, 2006, and Orders on Intervention and Procedures dated June 15, 2006, Intervenor Maine State Chamber of Commerce (the "Chamber"), by and through its attorneys, hereby submits its Brief.

I. INTRODUCTION.

This matter involves the Dirigo Health Agency's Board of Director's ("Board") May 12, 2006 oral determination, following a two-day adjudicatory hearing held on May 8 and 10, 2006, that there was approximately $41.7 million of "aggregate measurable cost savings" ("AMCS") pursuant to 24-A M.R.S.A. § 6913(1) ("Board's Oral Determination"). **Administrative Record, Binder 11, pp. 5197-5280 (hereinafter AR __, p. __)**. The AMCS consisted of the following individual amounts and time periods during which savings was measured:

Hospital Savings Initiatives (7/1/03-6/30/05):	**Mercer Recommendation**	**Board Adopted**
Case Mix Adjusted Discharge ("CMAD"):	$72.5 million	$14.5 million
Uninsured Savings Initiatives (7/1/05-12/31/06):		
Bad Debt and Charity Care ("BD/CC"):	$2.7 million	$2.7 million
MaineCare Adult Expansion:	$3.9 million	$3.9 million
Woodwork Effect:	$57,000	$57,000

Certificate of Need/Capital Investment Fund Initiatives (1/1/2007-12-31-2010):

CON/CIF:	$5.4 million	$5.4 million

Health Care Provider Fee Initiatives (approximately 1/1/06-12/31/2008):

Hospital Periodic Interim Payments ("PIP"):	$ 7.0 million	$ 7.0 million
Physician Fee Increase:	$ 8.2 million	$ 8.2 million
TOTAL	$99.9 million	$41.757 million

The Board's Oral Determination was subsequently reduced to a written Decision and Order that was adopted by the Dirigo Board on or about June 6, 2006 ("Board's Determination"). **AR 11, pp. 5281-5299.** The Board's Determination, along with the administrative record created at the adjudicatory proceeding, was filed with the Superintendent of Insurance ("Superintendent") on or about June 9, 2006, in an attempt to satisfy 24-A M.R.S.A. § 6913(1) (collectively the "Dirigo Filing").

A. Procedural Background.

By notice dated January 27, 2006, the Board initiated the underlying proceeding for the purpose of determining the AMCS. In that notice, the Board established the deadline for intervention and acknowledged that the hearing would be conducted in accordance with the Maine Administrative Procedures Act. The Board ordered the hearing to commence on March 15, 2006, acknowledging that "[t]he Board must make its determination [of AMCS] no later than April 1, 2006."

Included with the notice, the Board provided to interested parties a draft procedural order which, among other things, established deadlines for exchange of witness lists, documents, witness summaries, expert designations, identification of alternative methodologies for calculating the AMCS, and submission of pre-filed testimony and exhibits. All of these deadlines were established with the goal of commencing the hearing on March 15. The draft procedural order provided no time or mechanism for obtaining discovery of any kind. The

Chamber and other intervenors objected to the draft procedural order, among other things, because it required simultaneous case submissions, despite that DHA was the party moving for approval of its AMCS methodology and calculation. The Chamber also objected to the failure to provide for an opportunity for discovery in the procedural order and presented an alternative procedural schedule that provided a short period for discovery and the hearings to commence on March 22, still leaving sufficient time for the Board to render its decision before the April 1st deadline.

By order issued February 17, 2006, the Board rejected the Chamber's arguments, ruling in relevant part as follows:

> The Legislature has directed the Board to determine "annually not later than April 1st the aggregate measurable savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M. R. S. A. §6913 (1)(A) . . . .
>
> The applica[nts] object that the Draft Order [sic] does not provide for discovery. This is an administrative proceeding governed by the Maine Administrative Procedures Act. ("APA") The Act does not require that there be an opportunity for discovery. To the extent the Dirigo Health Agency has information that is not publicly available from other sources that applica[nts] believe is necessary to prepare their case, applica[nts] can request the information under the Maine Freedom of Access Act. Related to this objection is the objection of application [sic] to the schedule for [sic] established for the proceeding. The schedule is driven by the short time frame the Legislature has established for the Board to make a determination of aggregate measurable cost savings; informed by the fact that the proceeding comes on the heels of an adjudicatory hearing before Superintendent of Insurance in October 2005; and the familiarity of all interested persons with the issues presented.
>
> With regard to the charge of the applica[nts] that parties have not be given enough time to prepare a case, the Board notes that the Dirigo Act as originally enacted in 2003 included the requirement that the Board, after an adjudicatory hearing, make a determination of aggregate measurable cost savings not later than April. This provision was carried over into Chapter 400. Applica[nts] were members of, or attended the meetings of, the Working Group and were parties to proceedings before the Superintendent in October 2005. Applica[nts], therefore, have had more than sufficient notice that the Board would be holding an adjudicatory hearing prior to April of 2006.

Order on Intervention and Objections, issued February 17, 2006.

The Board thereafter issued a Third Procedural Order, calling for commencement of the hearings on March 27, 2006. However, the Order did not provide for discovery, and still required simultaneous submission of witness information, methodologies and documentation.

As directed in the Board's ruling regarding discovery, intervenors MEAHP and Anthem BCBS promptly (on February 24 & 28, respectively) served FOAA requests in an effort to obtain from the DHA and the Board the information relevant to the methodologies proposed for calculation of the AMCS. The Chamber joined in the FOAA requests of the MEAHP and Anthem BCBS. As will be explained in more detail below, DHA failed to produce a single document in response to these requests from any of the consultants relied upon by the DHA for development of the methodologies used in the calculation of AMCS until April 20, 2006. Furthermore, the disclosed documentation did not address the new methodologies and calculations ultimately proposed by the DHA on May 2, 2006.

Pursuant to Procedural Order No. 3, all parties were required to designate witnesses, provide witness summaries, designate experts and exchange documents by 5:00 p.m. on March 10, 2006. The order also required the parties to identify any alternative methodology for calculation of AMCS and provide supporting data by 5:00 p.m. on March 13, 2006. On March 7, 2006, DHA moved to continue the hearing, suggesting that it was unable to go forward because, according to DHA, not all of the data DHA deemed important to its calculation of AMCS would be available until July 1, 2006 and that the hearing in the Underlying Proceeding should be delayed until August.

The DHA requested in its motion that the Board suspend the procedural deadlines pending consideration of the motion, but the Board did not act on that request. Instead, those deadlines remained in place and the Hearing Officer[1] directed the parties to submit memoranda

[1] The Board retained James Smith, Esq. to act as the Hearing Officer in the Underlying Proceeding.

of law in support of their positions on DHA's Motion by 5:00 on March 13, with oral argument scheduled for March 14.

Despite the fact that DHA had yet to produce any documentation for meaningful analysis, the Chamber complied with the Board's deadlines, filing their witness designations, witness summaries, document designations and designations of experts on March 10 as required. The Chamber also identified the proposed alternative methodology by the March 13 deadline required by the Board.

Notwithstanding the still-in-force procedural deadlines imposed by its Board on all of the parties, DHA failed to comply with any of the deadlines: they filed no witness designations, no expert designations, no witness summaries, and did not designate, much less produce, any documents.

On Monday, March 13, pursuant to the request of the Hearing Officer, intervenors and DHA submitted memoranda of law in support of their respective positions on DHA's Motion to Continue. In those filings and during the oral argument on the DHA Motion on March 14, intervenors pointed out, *inter alia*, that (a) the statute clearly and unambiguous requires a determination by the Board of AMCS not later than April 1, 2006; (b) intervenors, particularly Anthem BCBS and MEAHP, would suffer significant prejudice if the DHA Motion were granted; (c) the Medicare cost report information that DHA asserted as the sole reason to delay was irrelevant to the AMCS, but even if relevant; (d) the Medicare cost report information for the vast majority of Maine hospitals is currently available, which meant that DHA could go forward and put on its case and enable the Board to comply with its statutory deadline to issue a decision that would (i) establish the methodologies for calculation of AMCS for the second year SOP assessment, and (ii) include the data currently available with an appropriate mechanism to

include the remaining data in the follow-up adjudicatory proceeding before the Superintendent of Insurance.

The intervenors also pointed out at the hearing that DHA had yet to produce any documents in response to the intervenors' FOAA requests. After discussion, the Hearing Officer ordered the DHA to (1) produce documents in response to intervenors' FOAA requests by March 17, (2) designate witnesses and provide witness summaries by March 17, and (3) identify its methodology for calculating AMCS by March 20.

On March 17, counsel for DHA informed intervenors that DHA would produce only those responsive documents in its possession and would not produce any documents in the possession of DHA's consultants, notwithstanding that the DHA consultants were primarily responsible for developing DHA's proposed methodology and had possession of all of the data and meaningful analyses that were responsive to the requests. When pressed on the legitimacy of this point, counsel for DHA agreed to contact DHA's consultants and request the responsive documents. When a response was not forthcoming, on March 20, intervenor Anthem BCBS filed a Motion for Clarification of the Hearing Officer's March 14 order. In that motion, Anthem BCBS outlined DHA's position and requested that the Board or Hearing Officer clarify that DHA must produce its consultants' responsive documents.

Instead of objecting to the Motion for Clarification, counsel for DHA thereafter indicated that DHA's primary consultant, Mercer Government Human Services Consulting ("Mercer"), had its own counsel and counsel would produce Mercer's responsive documents upon receipt of an administrative subpoena. Counsel for Anthem BCBS drafted and issued the administrative subpoena that same day, requesting that DHA obtain the signature of a Deputy Attorney General (as required by the applicable statute) and issue the subpoena.

Counsel for DHA promptly complied and issued the administrative subpoena, which required production of the responsive documents by 12:00 noon on Friday, March 24, 2006, one business day in advance of the hearing that was then scheduled to begin on March 28. Instead of producing documents, Mercer's counsel sent an email on the evening of March 24 to the effect that Mercer would not be producing documents that day and that they would need a minimum of two weeks to produce responsive documents. By that point, it had been four weeks since the document requests had been served, and only one business day remained before the scheduled start of the hearing.

On March 20, 2006, the Hearing Officer circulated to the parties a Recommended Decision. In that decision, the Hearing Officer acknowledged the plain words of the Act, but found them to be directory, rather than mandatory. The Recommended Decision also acknowledged the timing issues that are at the core of the prejudice Petitioners would suffer if the motion were granted, but determined that "[t]his argument, however, would not appear to require the denial of the instant motion especially if the hearing was continued until early July 2006 rather than after August 1, 2006." Notwithstanding this conclusion, the recommendation was that the Board grant the DHA motion and hold the adjudicatory hearing "not later than August 15, 2006."

While recommending that the adjudicatory hearing commence not later than August 15, the Recommended Decision set no deadline by which the adjudicatory hearing would end and no deadline by which the Board would make its initial determination of AMCS. The Hearing Officer requested comments on, or objections to, the Recommended Decision by 4:00 on March 24 and indicated that the Board would hold a hearing at 9:00 on Monday, March 27 to consider the DHA Motion and Recommended Decision.

In addition to other arguments, Intervenors in their objections to the Recommended Decision clarified the significant prejudice they would suffer if the DHA Motion were granted. See, e.g., Anthem BCBS's Response to Recommended Decision dated March 24, 2006, pp. 2-5. In that response, Intervenor Anthem BCBS explained that: (1) the Act is designed to result in a final determination of the SOP by the Board in late June; and (2) a final Board-approved SOP in late June permits inclusion of the SOP in premium rates effective January 1.

On March 27, 2006, with three voting members of the Board present, the Hearing Officer opened the hearing, and indicated that the DHA Motion was ready for Board action. With brief comments, no acknowledgement of the statutory deadline, and no deliberation in public, the Board voted 3-0 to adopt the Recommended Decision, without modification.

On March 30, 2006, the Intervenors, including the Chamber, filed a Petition for Review of Refusal of Agency to Act and Request for Expedited Review. Maine Association of Health Plans, et al. v. Dirigo Health Agency Board of Directors, Kennebec Superior Court Docket No. AP-06-26. Following an expedited briefing schedule and oral arguments on April 14, 2006, the Court issued a Decision and Order directing the Board to provide an opportunity for an adjudicatory hearing and determine the aggregate measurable cost savings no later than May 12, 2006.

The hearing officer waited until April 25, 2006 to host a conference call to address issues related to the hearing scheduled for May 8 and 10, 2006. At that conference call, Intervenors once again complained about the failure of the hearing process to comport with due process, explaining that, among other items, that the DHA had not provided (i) an updated methodology for determining AMCS; (ii) supplemental pre-filed testimony; (iii) supporting documentation for its methodology; or (iv) documents responsive to the Intervenors' FOAA requests.

By an Order dated April 28, 2006, the Board's hearing officer ordered the DHA to produce supplementation of its witnesses' testimony by 5:00 p.m. on May 1, 2006. He further ordered Mercer, the DHA's consultants, to supplement its report to the Dirigo Health Agency by 5:00 p.m. on May 2, 2006. This information was required to include "Mercer's calculation of the AMCS and all documents considered, reviewed, or relied upon for the report."

The DHA subsequently provided the supplemental testimony at approximately 4:56 p.m. on May 1, 2006, only four (4) business days before the start of the hearing. This supplementation included the designation of a new witness. The DHA provided Mercer's supplemental report at approximately 5:21 p.m. on May 2, 2005, only three (3) business days before the start of the hearing. The supporting spreadsheets identified in the Mercer supplemental report were not provided until approximately 5:56 p.m. The Mercer supplemental report and the supporting spreadsheets identified, for the first time, the specific methodology employed by the DHA to determine AMCS, as well as the specific amounts of the various categories of savings.

The following day, counsel for the DHA acknowledged that the information provided on May 2 did not include, as required by the hearing officer's order, "all documents considered, reviewed, or relied upon for the report." Counsel for the DHA periodically provided additional documentation as late as the afternoon of May 5, 2006, the final business day before the hearing. However, even this supplemental documentation did not represent full compliance with the Hearing Officer's April 28 Order. In fact, some documents were not received until the close of the first day of the hearing on the evening of May 8, 2006.

The DHA's failure or refusal to comply with the deadlines identified in the various procedural orders, the DHA's failure or refusal to timely comply with the FOAA requests, the Hearing Officer's failure to order the production of this relevant information in a timely manner,

and the DHA's failure or refusal to provide this relevant information as required by the Hearing Officer's Order failed to provide a meaningful opportunity for Intervenors' (and Intervenors' experts) to review the information and fully prepare for the hearing, thereby prejudicing the Chamber's right to due process and a fair hearing.

The Board held an adjudicatory hearing on May 8 and 10, 2005. At that hearing, the DHA's witnesses made numerous references to calculations and documentation that had not been provided to the Intervenors. Following public deliberations on May 12, 2006, by a vote of 3 to 0, the Board determined that the operation of Dirigo Health had resulted in approximately $41.7 million in AMCS.

The Board adopted in whole the amount of "savings" proposed by Mercer for the Uninsured Initiatives, CON/CIF, and Provider Fee Initiatives, even though these "savings" amounts were based upon unsupported assumptions and theories that were contradicted by available data, utilized inconsistent periods of measuring purported cost savings, included "savings" that cannot, if at all, materialize until a future date, and double counted savings, among other items.

The Board also adopted, in part, the amount of "savings" proposed by Mercer for the CMAD Initiative, even though this "savings" amount was based upon unsupported assumptions and theories that were contradicted by available data, utilized inconsistent periods of measuring purported cost savings, included "savings" that cannot, if at all, materialize until a future date, and double counted savings, among other items.

On June 6, 2006, the Board issued a written decision purporting to adopt the Board's Determination of May 12, 2006. However, the Board's Decision and Order erroneously identified total AMCS as $42.270 million. The Board filed the Dirigo Filing with the Superintendent on June 9, 2006.

II. APPLICABLE LAW.

The statutory provision governing this proceeding is found at 24-A M.R.S.A. § 6913. It reads, in pertinent part, as follows:

> 1. Determination of cost savings. The following are the procedures for determining cost savings.
>
> > A. After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.
> >
> > B. Within 30 days of the board's determination pursuant to paragraph A, the board shall file with the superintendent its determination as well as the supporting information for that determination. The filing constitutes a public record.
> >
> > C. Following a public hearing held in accordance with the Maine Administrative Procedure Act and no later than 6 weeks following the receipt of the board's determination, the superintendent shall issue an order approving, in whole or in part, or disapproving the filing made under subparagraph B. … The superintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record.

24-A M.S.R.A. § 6913(1) (Supp. 2005).

By its plain language, this provision requires that any AMCS determined by the Board be "annual," "aggregate," "measurable," and "as a result of" (1) "the operation of Dirigo Health" and (2) "an expansion in MaineCare eligibility occurring after June 30, 2004."

Following the determination of AMCS, the Board must file its determination with the Superintendent. Section 6913(1)(B). The Superintendent is required to review this entire filing, which includes both the Board's "determination" of AMCS and the supporting information. Section 6913(1)(C). Thus, the plain language of the law requires the Superintendent to review all aspects of the Board's determination, both legal and factual.

III. THE BOARD'S DETERMINATION ADOPTED SAVINGS THAT ARE NOT CONTEMPLATED BY THE PLAIN LANGUAGE OF 24-A M.R.S.A. § 6913

The Mercer supplemental report identified four so-called "Initiatives for Cost Savings measurement," including Hospital Savings Initiatives, Uninsured Savings Initiatives, Certificate of Need ("CON") and Capital Investment Fund ("CIF") Savings Initiatives, and Health Care Provider Fee Savings Initiatives, all with their various components. See Mercer supplemental report at page 7 and 8. The Chamber's position with respect to the permissible scope of savings is simple: The only methodology permitted by the plain language of 24-A M.R.S.A. § 6913(1)(A), is one that interprets "aggregate measurable cost savings" to mean savings that are reductions to bad debt and charity care costs as a result of:

(1) The operation of Dirigo Health, and

(2) Any expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A). The Chamber contends that a measurement of the reduction in bad debt and charity care costs (as described above) is the only measurement properly before the Superintendent at this hearing. As explained below, all other purported cost savings are beyond the scope of 24-A M.R.S.A. § 6913(1)(A) and must be rejected.

A. Legal Standard for Statutory Construction.

The main objective in statutory interpretation "is to give effect to the Legislature's intent." First Union Nat'l Bank, 2005 ME 108, ¶ 8, 882 A.2d at 798 (citing City of Bangor v. Penobscot County, 2005 ME 35, ¶ 9, 868 A.2d 177, 180); see also Labbe v. Nissen Corp., 404 A.2d 564, 567 (Me. 1979) (stating: "The determination of legislative intent is the fundamental rule in the interpretation of a statute."). When seeking the Legislature's intent, we must first look to the language of the statute itself. Labbe, 404 A.2d at 567; David John Kennedy, *Statutory Construction in Maine,* 7 Me. Bar J. 148, 150 (1992). If the statute is unambiguous,

we must give the language its plain meaning. First Union Nat'l Bank, 2005 ME 108, ¶ 8, 882 A.2d at 798.

Additionally, the whole statutory scheme for which the section at issue forms a part must be considered so that "a harmonious result, presumably the intent of the Legislature, may be achieved." Id. (citing City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180). In doing so, nothing in a statute is "treated as surplusage if a reasonable construction supplying meaning and force is otherwise possible." City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180 (quoting Labbe, 404 A.2d at 567). Furthermore, statutory language will not be construed to effect absurd, illogical, or inconsistent results. Kimball v. Land Use Regulation Com'n, 2000 ME 20, ¶ 18, 745 A.2d 387, 392. Finally, if there is any ambiguity, then we may look beyond the statute to extrinsic sources such as the statute's legislative history or other external indicia of legislative intent. Irving Pulp & Paper, Ltd. v. State Tax Assessor, 2005 ME 96, ¶ 8, 879 A.2d 15, 18.

B. The Plain Language of the Statute Limits the Meaning of Aggregate Measurable Cost Savings.

At issue is the meaning of "aggregate measurable cost savings." Although this term is not defined by the statute, its meaning is made clear by applying the required rules of statutory construction.

(1) Savings Must Result from the Operation of Dirigo Health and an Expansion in MaineCare Eligibility.

The plain meaning of "aggregate" is "a mass or body of units or parts somewhat loosely associated with one another; the whole sum or amount." *Webster's 3rd New International Dictionary* (2002). In order for the word "aggregate" to be given force and effect and not treated as surplusage, the phrases that follow it must be the identifiable and measurable parts that are included in an overall amount. In other words, aggregate measurable costs savings must be comprised of the following parts: savings as a result of (1) the operation of Dirigo Health, and

(2) an expansion in MaineCare eligibility after June 30, 2004. Otherwise, the Dirigo Board would be able to include *any* cost savings experienced in the State of Maine -- whether or not related to healthcare costs. This would lead to an absurd and illogical result, and would be inconsistent with the section's placement in the "Dirigo Health Act." 24-A M.R.S.A. § 6901.

The use of the inflected form of the transitive verb "including" in the statute also supports this reading. "Including" means "to take in or comprise as a part of a whole." *Webster's 3rd New International Dictionary* (2002). Here, the aggregate measurable cost savings takes in or includes savings, such as bad debt and charity care, that are the result of the operation of Dirigo Health and an expansion in MaineCare eligibility. Since nothing in a statute may be treated as surplusage if a reasonable construction giving each word meaning and force is possible, City of Bangor, 2005 ME 35, ¶ 9, 868 A.2d at 180, "aggregate measurable cost savings" must be limited to those savings in the nature of a reduction or avoidance of bad debt and charity costs that are the result of the operation of Dirigo Health and an expansion in Maine Care eligibility. To conclude otherwise would render the statutory terms "as a result of" meaningless, and provide no limitation whatsoever on the term "aggregate measurable cost savings." Certainly, if the Legislature intended the term "aggregate measurable cost savings" to be limitless, it would have used the phrase "including, but not limited to" as it did in another section of the same statutory scheme. 24-A M.R.S.A. § 6908(7) ("Other state agencies, including, but not limited to, the bureau … shall provide technical assistance and expertise to Dirigo Health upon request.") (emphasis added).

Application of the familiar *ejusdem generis* rule of statutory construction provides additional support for the interpretation identified above. According to this rule, "a general term followed by a list of illustrations is ordinarily assumed to embrace only concepts similar to those illustrations." Penobscot Nation v. Stilphen, 461 A.2d 478, 489 (Me. 1983) (concluding that the

statutory term "internal tribal matter" embraced only those matters illustratively listed in the statute and other matters like them and holding that the statutory term did not include beano games); In re Roberts, 22 B.R. 215, 217 (Bankr. D. Me. 1982) (quoting United States v. Insco, 496 F.2d 204, 206 (5th Cir. 1974) (noting that "general and specific words, when present together, are associated with and take color from each other.")). Here, the term "aggregate measurable cost savings" is followed by a listing of types of savings: "any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility." 24-A. M.S.R.A. § 6913(1)(A). Thus, according to the rule of *ejusdem generis*, "aggregate measurable cost savings" is limited to specific savings, like bad debt and charity care, that result from the operation of Dirigo Health and an expansion in MaineCare eligibility.[2]

Significantly, Dirigo Health's own parsing of the plain language of § 6913(1) has produced a similar conclusion. Indeed, in the Board's filing with the Superintendent of Insurance for the First Assessment Year, the Board states in the cover letter: "The Act tasked the … [Dirigo Board] with annually determining the aggregate measurable cost savings as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility." (emphasis added).

(2) The Meaning of Dirigo Health.

The use of the phrase "the operation of Dirigo Health" provides additional insight regarding the Legislature's intent. The term "Dirigo Health" is defined in 24-A M.R.S.A. § 6902 as "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees

[2] Assuming that there is no specified limit on the calculation of "aggregate measurable cost savings," then the Legislature has impermissibly delegated its taxing authority to Dirigo Health and the Board. Indeed, Dirigo Health and its Board would have nearly unfettered authority to set a tax in the form of the SOP assessment.

and dependents on a voluntary basis." Dirigo Health is "also responsible for monitoring and improving the quality of health care in this State" through the Maine Quality forum. Id.; see 24-A M.R.S.A. § 6951. Because the Legislature has also defined the term "Dirigo Health Act" as chapter 87 of Title 24-A (24-A M.R.S.A. §§ 6901-6971),[3] the use of these different terms within the same statutory scheme effectively rules out any intention of the Legislature to capture cost savings as a result of the Dirigo Health Act generally, or as a result of Chapter 469. Since the Hospital Savings Initiatives, CON and CIF Savings Initiatives, and Health Care Provider Fee Savings Initiatives are not under the jurisdiction of Dirigo Health, they are not properly included as savings resulting from the operation of Dirigo Health, nor are they the result of a MaineCare expansion after June 30, 2004.

(3) The Entire Statutory Scheme Also Evidences the Legislature's Intent to Limit the Scope of Aggregate Measurable Cost Savings.

An interpretation of "aggregate measurable cost savings" that limits savings to those in the nature of a reduction in bad debt and charity care cost resulting from the operation of Dirigo Health and an expansion in MaineCare eligibility is further supported by and reflected in the entire statutory scheme. For example, another subsection of the statute requires health insurance carriers and health care providers:

> [T]o demonstrate and report that they have used their best efforts to obtain savings offset payments through negotiated reimbursement rates that reflect the provider's reductions or stabilization in the cost of bad debt and charity care as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24 M.R.S.A. § 6913(7) (Supp. 2005) (emphasis added). Likewise, Section 6913(7)(B) states that health care providers, when engaged in contract negotiations with carriers, "shall provide data relating to any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and as a result of any increased

[3] 24-A M.R.S.A. § 6901.

enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." Id. (emphasis added). Similarly, 24-A MRSA § 6913(8)(C) requires health insurance carriers and health care providers to:

> [R]eport annually . . . information regarding the experience of a prior 12-month period on the efforts undertaken by the carrier and provider to recover savings offset payments, as reflected in reimbursement rates, through a reduction or stabilization in bad debt and charity care costs as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

If the Legislature intended to define the term "aggregate measurable cost savings" more broadly, then it certainly would not have limited the carriers' and health care providers' reporting obligations to bad debt and charity care saving resulting from the operation of Dirigo Health and an expansion in MaineCare eligibility. Indeed, it would have specified additional reports related to voluntary cost and operating margin limitations, the CON moratorium, and MaineCare budget decisions, and required negotiations of reimbursement rates based upon these reports.

(4) Summary.

The plain language of the statute interpreted in accordance with the accepted canons of statutory construction unambiguously defines "aggregate measurable cost savings" to mean savings in the nature of reductions to bad debt and charity care costs as a result of:

(1) The operation of Dirigo Health, and

(2) An expansion in MaineCare eligibility occurring after June 30, 2004.

Therefore, these are the only sources of savings that the Superintendent may properly consider.

C. The Plain Language of the Statute Does Not Support the Hospital Savings Initiative, CON and CIF Savings Initiatives, and Health Care Provider Fee Initiatives

(1) Hospital Savings Initiative.

For the First Assessment Year, the Board asserted that the hospital savings arose from the voluntary limitations specified in Section F-1(B) of Chapter 469,[4] which read as follows:

> B. Each hospital … is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital's fiscal year beginning July 1, 2003 and ending June 30, 2004.

Id. This unallocated language does not apply to the Second Assessment Year, and there are no other statutory limits, voluntary or otherwise, relating to CMAD or COM for the Second Assessment Year. Undaunted, Dirigo Health points to statements made by the Maine Hospital Association ("MHA") as support for its Hospital Savings Initiative. See Mercer supplemental report at page 2. The assertion that statements from the MHA are equivalent to "as a result of the operation of Dirigo Health" does not pass the straight face test, and is not a valid basis for attributing any savings to Dirigo Health. In fact, even before the existence of Dirigo, as part of what was called the "Maine Health Care Challenge," a number of health care organizations and professionals agreed to limit their operating margins.[5] Dirigo Health cannot take credit for, and then base a tax on, every single health care initiative in Maine simply by virtue of the agency's existence.

Even assuming the MHA newsletter can somehow be ascribed to Dirigo Health, it does not follow that a hospital's attempt to comply with the MHA's 4.5% limit on cost increases per CMAD would produce "savings" to be measured under 24-A M.R.S.A. § 6913(1). Indeed, the

[4] P.L. 2003, c. 469.
[5] In essence, Dirigo adopted the Maine Health Care Challenge. See Dirigo Narrative, Chamber Exhibit 24, Tab 2 **AR 10, p. 4847**.

plain language of Section 6913 refers to savings "as a result of the operations of Dirigo Health" -- not as a result of the operations of the MHA. Dirigo Health was established "to arrange for the provision of comprehensive, affordable health care coverage …." 24-A M.R.S.A. § 6902. The powers and duties delegated by law to Dirigo Health reflect this purpose, and do not include monitoring or enforcing the voluntary limits on hospitals or other persons or entities like the MHA. 24-A M.R.S.A. § 6908 (specifying the powers and duties of Dirigo Health). Finally, voluntary cost limits are not in the nature of a reduction of bad debt and charity care costs, as required by the plan language of Section 6913(1). They are simply voluntary cost containment measures by hospitals. Therefore, the Chamber objects to the inclusion in "aggregate measurable cost savings" of any amount related to the Hospital Savings Initiatives.

(2) Health Care Provider Fee Initiatives.

The Proposed Year 2 Methodology contains a savings initiative entitled "Health Care Provider Fee Savings Initiatives," and conveniently includes the statement:

> The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives.

See Proposed Year 2 Methodology, **AR 1, p. 206**. Last year Dirigo Health justified its use of Medicaid payments as a measure of cost savings because Chapter 469 created the Commission to Study Maine Hospitals ("Commission"), and the Commission's Report ("Report") happened to mention various longstanding problems with hospital and physician Medicaid funding in a section explaining "cost shifting." The DHA adopted a similar approach this year. While creative, this attenuated connection does not satisfy the plain language of Section 6913. Again, the law requires savings "as a result of the operations of Dirigo Health" -- not as a result of the Dirigo Act, the Commission, or Chapter 469.

Moreover, neither Dirigo Health nor the Commission has the authority to administer the MaineCare program. Pursuant to the MaineCare State Plan (a document required by the federal

government), the Office of MaineCare Services ("OMS") within the Department of Health and Human Services is the single state agency authorized to administer the MaineCare program--not Dirigo Health. See Testimony of Geoffrey Greene, **AR 11, p. 5052 (p. 317, lines 1-14).** Thus, any alleged "savings" cannot be the result of the operation of Dirigo Health. Further, even assuming that Dirigo Health can bootstrap MaineCare payments into Dirigo Health "savings," there is no basis for concluding that long overdue payments represent "cost savings." Indeed, MaineCare currently owes Maine Hospitals over $200 million (**AR 9, p. 4270-4272)**, yet the DHA refuses to offset the continuing costs of slow payment against the alleged cost "savings." Therefore, the Chamber objects to the inclusion in "aggregate measurable cost savings" of any amount related to the Health Care Provider Fee Savings Initiatives.

(3) CON/CIF.

Mercer's supplemental report purports to calculate CON/CIF savings by reference to two separate theories: Under the first theory (hereinafter referred to as the "CON Savings Methodology"), Mercer assumed that any hospital which revised or withdrew its CON application did so because of the operation of Dirigo Health. Mercer then netted the $400,000 third year operating cost threshold for CON review against the projected third year operating cost in the revised or withdrawn application, and reduced the future avoided third year operating cost "savings" to present value. Mercer's CON Savings Methodology produced a value of $4,001,836.00. **AR 3, p. 1460.** Under the second theory (hereinafter referred to as the "CIF Savings Methodology"), Mercer looked at pending CON applications, compared the operating costs to the CIF limitation, determined that at least one of the projects would not fit within the CIF limitation, and then assumed any disapproval by DHHS necessarily would be based on the CIF limitation. Mercer's CIF Savings Methodology produced a value of $1,448,180.00, for total CON/CIF "savings" of $5,450,016.00. **AR 3, pp. 1461-1462.** Putting aside for a moment the

fact that Mercer's methodology produces values representing alleged savings far into the future (adjusted to present value), for the following reasons it is unreasonable to conclude, as a matter of law, that the CON activity Mercer observes relates in any way to the operation of Dirigo Health.

First, similar to the provider fee initiatives, Dirigo Health does not have the authority to approve or deny CON applications, and it does not administer the CIF. The DHHS administers the certificate of need program and debits against the CIF any amounts resulting from approval of CON applications. See Testimony of Catherine Cobb, **AR 11, p. 5033 (p. 242, lines 9-18).** Dirigo Health does not play any role in the review, approval, or denial of any CON application. Therefore, the CON/CIF Savings Methodologies do not measure anything resulting from the operation of Dirigo Health.

Second, assuming the $400,000 threshold would have been the basis for review of the CON submissions at issue, this threshold, which serves as the basis for Mercer's CON Savings Methodology, pre-existed Dirigo Health. See Testimony of Catherine Cobb, **AR 11, p. 5033 (p. 243, lines 13-23)**; see also Public Laws 2001, Chapter 664 (establishing $400,000 threshold effective July 25, 2002). Therefore, Dirigo Health cannot be the reason that hospitals withdraw or revise CON submissions. By way of explanation, Mercer's supplemental report states: "After concentrated study, it was noted that several large hospital CON submissions were withdrawn and revised to comply with the third year threshold for operating costs." **AR 3, p. 1445.** Based on this untested assumption, Mercer measures the future avoided third year operating costs allegedly on account of the $400,000 CON threshold, and then attributes this number as Dirigo Health savings. However, if Mercer had broadened the scope of its concentrated study, it would have realized that the $400,000 threshold for CON review was effective beginning July 25, 2002. See Public Laws 2001, Chapter 664. Clearly it is not reasonable to attribute savings to

Dirigo Health where the basis for the savings is a statutory provision that existed before Dirigo Health.

Third, because Mercer did not bother to contact any hospitals to confirm its assumption that CON submissions were revised or withdrawn to comply with third year operating cost thresholds, there is no factual basis for it. See Testimony of Steven P. Schramm, **AR 11, p. 5046 (p. 294, line 21 through p. 296, line 2)** (acknowledging that Mercer based its analysis on conversations with Ms. Catherine Cobb and her CON unit, and did not contact any hospitals)**.** In fact, Dirigo Health provided no documentation or testimony which specifically links any CON revision or withdrawal to Dirigo Health. See Testimony of Catherine Cobb, **AR 11, p. 5034 (p. 247, lines 5-13)** (indicating lack of knowledge as to exactly why Maine Medical Center withdrew its submission, but "belief" that they withdrew to avoid CON review, which pre-existed Dirigo Health)**; AR 11, p. 5040 (p. 270, lines 14-25)** (confirming that there is no record of anyone from DHHS or Mercer contacting hospitals to inquire whether Dirigo Health played any role in decision to withdraw or revise CON submission). In reality, hospitals may revise or withdraw their CON submissions for any host of reasons, such as a shift in strategic planning and growth strategy, a change in administration, a material change in construction costs or financial feasibility, etc. See Testimony of Catherine Cobb, **AR 11, p. 5036 (p. 254, line 13 through p. 255, line 12)**; Testimony of Steven Michaud, **AR 9, p. 4313, lines 15-21.** Nowhere, however, is there any indication that Dirigo Health actually asked the hospitals why they revised or withdrew their CON submissions. To simply assume that any revision or withdrawal is attributable to CON thresholds, let alone Dirigo Health, is unreasonable.

Finally, to suggest that Inland Hospital's withdrawal was somehow related to Dirigo Health thresholds when there was a competing application from MaineGeneral Medical Center in the same relatively small service areas ignores the reality of CON review. As Ms. Cobb

acknowledged in her pre-filed testimony (**AR 3, p. 1278**), one or both of these applications could have been denied "on the merits", which would have nothing to do with even the Dirigo Health Legislation, let alone the operation of Dirigo Health. Similarly, the CIF Savings Methodology unreasonably assumes that the DHHS will necessarily deny at least one of the CON submission because of the CIF limitation. On the contrary, it is entirely likely that a CON submission would be denied on the merits, without regard to the amount of credits in the CIF.

For all of the foregoing reasons, the Chamber objects to the inclusion in "aggregate measurable cost savings" of any amount related to the CON/CIF Initiatives.

D. The Legislative History of the Statute Does Not Support the Hospital Savings Initiative, CON/CIF Savings Initiatives, and Health Care Provider Fee Initiatives

The Legislative intent is clear from the plain language of 24-A M.R.S.A. § 6913(1)(A). Aggregate measurable cost savings is intended to be a measure of any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of:

(1) The operation of Dirigo Health, and

(2) Any increase in MaineCare enrollment due to an expansion in MaineCare eligibility.

The Board's Determination goes far beyond measuring reductions in bad debt and charity care, and attempts to credit Dirigo Health with purported savings generated by completely separate and independent government initiatives in the field of healthcare. This is contrary to the plain and unambiguous language of § 6913(1)(A). However, even assuming some ambiguity exists, the legislative history is replete with testimony, statements, and comments which demonstrate that reductions in bad debt and charity care were intended to be the only basis for computing aggregate measurable cost savings and the resultant tax on health care claims.

For example, at a May 15, 2003 public hearing before the Joint Select Committee on Health Care Reform ("Joint Select Committee"), a representative of the Governor's Office of Health Policy and Finance testified as follows with regard to L.D. 1611:

> Those uninsured citizens seek care only when no other option is available – at late and costly stages of disease. Hospitals and other providers care for them at no charge, then raise their rates to cover the losses associated with that care. Those increased rates are charged to insurance premiums in the form of a cost shift that all of us pay. As a result, there is today $275 million already in the system that covers bad debt and charity care to pay for the uninsured when they get sick. We propose to reinvest less than a third of **that money** to help pay for health insurance coverage including coverage for prevention and primary care, for all Maine's uninsured. This will provide a payment source for health care services and avert the need to shift charity care costs to others. We propose recapturing **those funds** through an assessment of 4.0% on the gross revenues of insurance companies, which could not be passed on to consumers. Again, **it** [bad debt and charity care] is money already in the system and therefore, despite assertions to the contrary, premiums will not be allowed to increase when we recover those costs.

See Testimony of Trish Riley, Director, Governor's Office of Health Policy and Finance, Before the Joint Select Committee on Health Reform, May 15, 2003 (emphasis added). **AR 10, p. 4732.** Likewise, at the same public hearing Honorable Senator Sharon Treat, Senate Majority Leader and Lead Senate sponsor of L.D. 1611, testified as follows on the issue of financing Dirigo Health:

> Specifically, the [Dirigo] plan pools a variety of resources, relying on:
> . . .
>
> Insurance companies who will pay "up front" for less expensive preventative health care, rather than the more expensive "bad debt and charity care" frequently provided to the uninsured and underinsured in hospitals.

Testimony of Sharon Anglin Treat, Senate Majority Leader, to the Joint Select Committee on Health Care Reform, May 15, 2003 (emphasis added). **AR 10, p. 4741.** This testimony, on behalf of the Dirigo Health Agency and by the bill's lead sponsor, is unequivocal; bad debt and charity care was intended to be the only basis for determining aggregate measurable cost savings.

Additional support for the above conclusion is found in answers to questions posed by the Joint Select Committee, which were submitted by the Governor's Office of Health Policy and Finance about a week after the May 15, 2003 public hearing. See Responses to Committee Questions--Governor's Office of Health Policy & Finance. **AR 10, p. 4742.** Indeed, the very first question posed is:

> Why is the proposal funded solely from a tax on insurers and not a broader funding mechanism?

And the answer begins:

> The purpose of the assessment is to recover bad debt and charity care now implicit in the prices [for health care services].

The answer goes on to justify the tax on the basis that "the reimbursement rates paid by insurers will not incorporate the cost of bad debt and charity care, but the premiums paid by rate payers will, resulting in a potential windfall to insurers …." Throughout this document there are repeated references to bad debt and charity care as the only basis for aggregate measurable cost savings and the resultant SOP assessment.

Yet another example illustrating the original intent is a handout from the Governor's Office of Health Policy and Finance, dated June 11, 2003. This handout refers to the unanimous report of the joint select committee and coincided with upcoming floor debate. It stated with respect to the financing of Dirigo Health:

> Capture realized savings from the reduction in bad debt and charity care through the savings offset payments . . .. Payments will be made by insurers to Dirigo Health only after savings are shown.

See handout from the Governor's Office of Health Policy and Finance, dated June 11, 2003 (emphasis added). **AR 10, p. 4750.** As explained by this handout, the testimony before the Joint Select Committee, and the written answers to the Joint Select Committee's questions, the financing of Dirigo Health was intended to be directly connected with, and thus limited to,

reductions in bad debt and charity care. To use Dirigo Health's own words, the funds that are to be "captured," must be "realized savings from the reduction in bad debt and charity care." Id. The reduction may be (1) as a result of the operation of the Dirigo Health insurance product or (2) as a result of expansions in MaineCare coverage. Nowhere in the testimony before the Joint Select Committee, written answers to the Joint Select Committee questions, or the June 11, 2003 handout from the Governor's Office of Health Policy and Finance, however, does it mention financing Dirigo Health via other initiatives, completely independent of and unrelated to reductions in bad debt and charity care.[6] It only stands to reason that if the intent was for Dirigo Health to be funded almost entirely by initiatives wholly separate and distinct from those aimed at reducing bad debt and charity care, then this would have been explained or at least mentioned in the statute or legislative history. Tellingly, there is nothing in the statute or legislative history to support Dirigo Health's interpretation and, in fact, Dirigo Health's interpretation is contrary to the plain language and legislative history of 24-A M.R.S.A. § 6913(1)(A).

Lest there be any remaining doubt, numerous statements made by legislators during floor debate further demonstrate the Legislature's intent for Dirigo Health to be funded only by measurable reductions in bad debt and charity care. For example, during debate of the original bill, Representative Glynn stated:

> I did want to explain a little bit about [how] the savings offset premium payments work and how the assessment is going to be made. Essentially the way the offset payments are going to be assessed is that when folks sign up for Dirigo it is anticipated that there is going to be a reduction in bad debt and charity care at doctor's offices and hospitals. Those savings are expected to be in a large amount of money. Those savings are expected to be reflected in reductions and rates at

[6] The Chamber could go on for pages citing the various documents that, from the inception of Dirigo Health, would demonstrate to any objective reader that bad debt and charity care reductions were to be the only basis for the savings offset payment. By way of another example, the Dirigo Narrative dated May 5, 2003, states repeatedly throughout that reductions in bad debt and charity care will fund Dirigo Health. No other "savings" initiatives are mentioned. See Dirigo Narrative, **AR 10, 4788 et seq.** (pages 20, 26, 27, 30, etc.). Interestingly, at page 57 of the narrative, bad debt and charity care is described as representing a "substantial indirect, hidden tax on health insurance premiums and costs to fully and self-insured health plans in the state as well as those persons paying out of pocket for their own care." The Chamber submits that this is exactly what the SOP has become as a result of basing it on purported savings that have nothing to do with bad debt and charity care reductions.

> hospitals and at doctor's offices. It is then expected that because the savings are reduced at doctor's offices and hospitals that that savings in turn is going to be passed onto the insurance carriers, which, in turn, will ultimately be passed on to the businesses and also passed onto the consumer.
> . . .
>
> However, which is important, is the tax that will be assessed (sic) up to that maximum cap will never be greater than the bad debt and charity care that are actually going to be realized by both the hospitals and doctor's offices, that is then realized by the insurance carriers, which then will offset that tax.

Legis. Rec. H-985 (1st. Reg. Sess. 2003) (Statement of Rep. Glynn) (emphasis added), **AR 10, p. 4756.**

Unfortunately, DirigoChoice enrollment fell well short of projections, and the savings related to reductions in bad debt and charity care, which were expected to be a large amount of money, were in fact about $2.7 million for the first assessment year. This is not enough to sustain Dirigo Health. As a result, recent amendments to Section 6913, although not altering any of the language at issue, caused additional debate on the scope of aggregate measurable cost savings because, by this time, Dirigo Health knew it could not identify sufficient savings from bad debt and charity care alone to sustain the agency and its insurance product. Knowing this, Dirigo Health apparently indicated that it intended to expand, without authority, the scope of measurable savings for the First Assessment Year to include other, independent government initiatives relating to health care in Maine. For example, Senator Mills noted:

> One of the answers (sic) that we will try to make is that we are saving the money through other things that Dirigo is doing. The original theory of the Dirigo product was that by taking people off the uninsured list and giving them insurance that this would save on bad debt and charity care. I have no doubt that there will be some small measure of savings arising from the sale of this product to people who are uninsured. I believe that this savings will be miniscule. Because it is miniscule, I understand that the directors of Dirigo plan to take credit for, and maybe they should, other initiatives of the Dirigo program in a broader context. One of the awkward things in our discussion is that the Dirigo label is used not just for the health product, which is one initiative, but also for a whole set of government initiatives in the field of healthcare; the new controls over certificate of need, the efforts to gain control over hospital costs, and to gain voluntary compliance to limits on the growth in healthcare expenses. All of those things are

> initiatives of government that could have taken place, and indeed have taken place, in a fashion that is completely independent of the sale of the Dirigo Health product. In an effort to justify the savings to the healthcare system globally or as a whole, the product which benefits a comparatively few people will be subsidized by savings that are generated through the activity of government more broadly and savings that could have redounded to the benefit of the private sector without the sale of the product.

Legis. Rec. S-1238 (1st Spec. Sess. 2005) (Statement of Sen. Mills) (emphasis added), **AR 10, p. 4777.** In response to this statement recognizing the agency's representations, other Senators reiterated the clear and unambiguous intent of the statute as it was enacted. Senator Mayo stated:

> It was my understanding two years ago, and it is still my understanding this afternoon, that this 4% savings off-set payment is tied to charity care and bad debt, and that if charity care and bad debts are not reduced on the part of the hospitals, doctors, and etcetera, then we do not have, under current statute, the ability to impose the savings off-set payment because the two were tied together.

Legis. Rec. S-1239 (1st Spec. Sess. 2005) (Statement of Sen. Mayo), **AR 10, p. 4778.** Similarly, Senator Turner stated:

> [T]here is the savings off-set payment which the Senators from Sagadahoc, Senator Mayo, and Somerset, Senator Mills, have talked about. This was tied to bad debt and charity care. Our expectation was that if that was documented and validated then by gosh we should capture that because this effort under Dirigo has made that come to pass. I don't want to put words into the Senator from Sagadahoc, Senator Mayo's mouth, but I think he said the payments are, perhaps, miniscule and that may have been attributed to the Senator from Somerset, Senator Mills, but it was in the ether here this afternoon. The fact is we do not have anything to hang our hat on with respect to the savings off-set payment. We don't know whether that piece works but we do know we have a savings off-set payment calculation that is calculated on nothing at this point in time.

Legis. Rec. S-1240 (1st Spec. Sess. 2005) (Statement of Sen. Turner), **AR 10, p. 4779.**

Thus, despite the understandable efforts by Dirigo Health to maintain the very existence of the Dirigo Health Agency and the Dirigo Health insurance product by expanding the measure of aggregate measurable cost savings through administrative fiat, the inescapable conclusion gleaned from reviewing the legislative history of § 6913 is that reductions in bad debt and charity care are the only basis for measuring aggregate measurable cost savings. The separate and

independent initiatives in the Dirigo Legislation, such as controls over certificate of need, the voluntary limit on hospital operating margin, etc., were never intended to be measures of aggregate measurable cost savings. On the contrary, as noted in answers to the Joint Select Committee, these independent initiatives were intended simply to benefit Dirigo and other insurance plans generally, "as part of a comprehensive systems improvement." See Responses to Committee Questions--Governor's Office of Health Policy & Finance at answer to question No. 4 (stating with respect to the separate initiatives: "Dirigo, like other insurance plans, will benefit from the impact cost containment exercises on the system"). **AR 10, p. 4744-4745.** In sum, although understandable in light of Dirigo Health's less than favorable financial prognosis, Dirigo Health's efforts to expand the scope of aggregate measurable cost savings in order to save the agency and its insurance product are contrary to the plain language and legislative history of 24-A M.R.S.A. § 6913(1)(A), and in fact result in a true health care tax--which was never the intent.

F. The Plain Language of the Statute Does Not Support Counting "Savings" in Different Time Periods.

The language of the Section 6913(1) plainly contemplates an "annual" determination. This requires the Board to measure savings within a consistent one year (twelve month) period. As illustrated above, the Board measured "savings" in different time periods -- past, present and future. For example, the CMAD calculation measured "savings" for SFY 2005 (July 1, 2004 to June 30, 2005). However, the Uninsured Initiatives measured savings that occurred in calendar year 2005 and 2006, and the CON/CIF addressed "savings" from calendar year 2007 to calendar year 2010. Finally, the Provider Fee Initiatives apparently cover three years of alleged time value of money "savings." The Chamber objects to any "savings" that have not yet occurred, as well as the "savings" that did not actually occur in SFY 2005. To allow the Board to include savings from a five year period would render the term "annually" meaningless.

G. The Plain Language of the Statute Does Not Support Double Counting "Savings."

The Board's methodologies for CMAD, Uninsured Initiatives, CON/CIF and Provider Fee Initiatives all double count savings in one form or another. For example, the CMAD savings methodology necessarily includes "savings" that were recovered in the first assessment year because the actual growth rate for SFY 2005 exceeded the historical growth rate. Similarly, the Board's Uninsured Initiatives methodology not only counts the theoretical "savings" from Dirigo Choice members enrolled in calendar year 2006, but also includes the "savings" for those who enrolled in calendar year 2005 (even though this savings was also recovered in the first assessment year). The DHA's witnesses for CON/CIF both agreed that any costs associated with a CON application, construction and operation would be included in that hospital's cost per CMAD. Accordingly, the Board's methodology will capture these "savings" twice. Finally, with respect to the Provider Fee Initiatives, the Board's methodology double counts PIP "savings" by including the difference between SFY 2007 PIP and SFY 2005 PIP in the "savings" calculation, although the actual increase for 2007 would be (at best) the difference between 2006 and 2007. The Chamber objects to any "savings" that are the result of double counting, and submits that it is not reasonable to do so.

IV. EVEN ASSUMING THE SAVINGS INITIATIVES IDENTIFIED IN THE BOARD'S DETERMINATION MAY BE CONSIDERED IN AMCS, THE METHODOLOGIES ADOPTED BY THE BOARD ARE UNREASONABLE.

With the exception of CMAD, the Board adopted in whole the methodologies proposed by Mercer. As explained in more detail below, the methodologies adopted by the Board are not reasonable and do not find support in the administrative record.

A. Hospital Savings Initiatives (CMAD).

For the first assessment year, the Board projected SFY 2004 cost per CMAD using the hospitals' historical cost data, and then measured the projection against actual SFY 2004 costs

data. Analysis of the underlying documentation proved that the Board's methodology was flawed because it confused natural random fluctuations with Dirigo-related "savings." For the second assessment year, the Board adopted a methodology that used the exact same historical data and projection method, but this time it combined all of the hospital data into a single "mythical" hospital. While this methodology may cure last year's issue of only looking at reductions and disregarding increases, this methodology suffers from the same problems as the prior one. It still simply manipulates raw data, and fails to provide analyses to separate the Dirigo-related savings (if any) from other factors and trends affecting hospital cost growth rates. This approach, like last year's, simply measures random fluctuations from year to year. Worse yet, it intensifies the effect of naturally occurring fluctuations such as volume. Therefore, as explained more fully below, the methodology adopted by the Board is not a reasonable measure of savings (if any) that result from the operation of Dirigo Health.

(1) The Board's Methodology Fails to Properly Reflect the Alleged 4.5% Limit on Increased Cost per CMAD.

The sole basis for the alleged CMAD "savings" is an MHA press release announcing voluntary efforts by MHA members to keep cost increases to 4.5% when measured on a cost per CMAD. Even assuming that a MHA's press release can form the basis for Dirigo-related savings, the Board's methodology for CMAD "savings" must fail because it completely disregards the 4.5% target. If the target is applied, there would be no savings for the second assessment year. Indeed, as shown by Mercer's own calculations, the percentage increase in cost per CMAD from SFY 2004 to SFY 2005 was approximately 6.9%, a number that substantially exceeds the MHA target of 4.5% (as well as the projected historical trend of 6.2%).

(2) There Can be No CMAD Savings Without a Limit on Operating Income.

Further, even assuming CMAD is a proper savings initiative, the DHA and the Board have conceded that there was no limitation on consolidated operation margin ("COM") for the

second assessment year. Without a COM limit, there is nothing that "requires" a hospital to voluntarily turn over any cost savings to commercial payors. Furthermore, the Board's failure to measure operating income for SFY 2005 leaves no basis to conclude that the hospitals actually could afford to pass along the alleged CMAD "savings." Indeed, as reflected in the COM calculations for the first assessment year, most Maine hospitals had a slim operating margin, and many had an operating loss. **Chamber Exhibit 13, AR 9, p. 4266.** The Board's failure to calculate COM for SFY 2005 is yet another example of why its methodology is unreasonable.

(3) The Board's CMAD Methodology Confuses Naturally Occurring Fluctuation with Dirigo-Related "Savings".

A brief review of Mercer's CMAD spreadsheet proves that -- even on an aggregate basis -- hospital costs per CMAD fluctuate randomly from year-to-year. For example, Mercer's analysis shows the following percentage changes in cost per CMAD from 1999 to 2005:

2000 to 2001	4.7%
2001 to 2002	10.1%
2002 to 2003	3.3%

Chamber Exhibit 21, AR 10, p. 4687. Because cost per CMAD fluctuated significantly in the pre-Dirigo period, it is unreasonable to conclude that post-Dirigo fluctuations are attributed solely to Dirigo Health. Even Mr. Schramm, the DHA's principal witness on CMAD, admits that the methodology was not designed to "parse out" Dirigo-related savings from those naturally occurring fluctuations -- or even those caused by other factors such as changes in volume, payor mix, Medicare/Medicaid payment cuts, or employer initiatives. **AR 11, p. 5115 (p. 95, line 9 - p. 96, line 10).**

More importantly, it stands to reason that a formula designed to measure the impact of Dirigo Health should not produce "savings" in places and times not covered by Dirigo Health. Indeed, such a formula merely proves that the measured shift in cost trends cannot possibly be

related to Dirigo Health, but instead is explained by external forces that cause cost per CMAD to shift on a random basis.

As illustrated above, the DHA's own documentation proves that cost per CMAD randomly fluctuated prior to the enactment of the voluntary limits in Maine. Furthermore, Mr. Schramm freely admitted that actual cost numbers will vary from the baseline projections. **AR 11, p. 5116 (p. 97, line 23 - p. 98, line 1).** Therefore, the DHA formula will always produce a "number" in other areas, other states, other times. However, the DHA argues that this number is "savings" only when the "number" produced falls within in a time and place covered by Dirigo Health. The DHA witnesses attempt to justify this *non sequitur* by invoking the "critical hypothesis" that Dirigo is a "primary driver" of the cost trend shifts in 2005 (but not other places or times). **AR 11, pp. 5119-5120 (p. 111, line 20 - p. 113, line 12).** In other words, the DHA would have the Superintendent believe that the external influences that produced substantial fluctuation in Maine for previous years have all magically disappeared in 2005, and therefore it is safe to assume that the any downward cost trend shifts are solely attributable to Dirigo Health.

However, simply saying that Dirigo was the "primary driver" obviously does not make it true. Admittedly, neither the DHA nor its consultants made any attempt to verify the accuracy of this "critical hypothesis," and, as discussed below, in fact they affirmatively turned a blind eye to overwhelming evidence that compels rejection of the theory. **AR 11, p. 5119 (p. 111, line 5 - p. 112, line 2)** (Mr. Schramm acknowledged that Mercer did not: contact hospitals to confirm "savings"; conduct written surveys to verify "savings"; verify "savings" by applying the methodology in other states; verify "savings" by applying the methodology in Maine before Dirigo).

Nevertheless, Mr. Schramm argued that the Board could properly rely upon the "critical hypothesis." However, the "critical hypothesis" is fatally flawed. First, it relies upon the

formula's outcome as the only proof of its reliability. Put differently, the DHA suggests that the fact that the formula produced "savings" for the period ending June 30, 2005 is proof that Dirigo Health was responsible for the savings because it was the "primary driver." The conclusion that the voluntary limits were the "primary driver" would be more plausible if there was an absence of "savings" (or at least very little) in the years prior to the voluntary limits. However, it is undisputed that application of the CMAD methodology in Maine produced almost the exact same "savings" for the period ending June 30, 2003 ($14.1 million) -- before Dirigo Health was proposed and enacted -- than it produced for 2005 ($14.5 million). **AR 10, p. 8.** The same "savings" in a year after Dirigo Health was enacted as calculated for the year before Dirigo destroys the "critical hypothesis," and compels a finding that random fluctuation – and not Dirigo Health -- is the "primary driver" in cost trends when measured by cost per CMAD. Again, it is not surprising that random fluctuation can have such a dramatic effect, because cost per CMAD consists of only two factors (total cost and total discharges), and if total discharges increase at a rate that exceeds the increase in total cost, simple arithmetic requires a lower cost per CMAD. Furthermore, Mr. Mercier provided undisputed testimony and documentary evidence that the Mercer CMAD methodology was highly sensitive to volume, and that small adjustments to volume produced significant changes to "savings." **AR 11, p. 5155; AR 9, p. 4301.**

Second, the same amount of savings before Dirigo Health as after cannot be explained away by the so-called "sentinel event" theory.[7] Indeed, the Dirigo law was first proposed in May 2003, enacted in June 2003, and became effective in September. Since hospital cost per CMAD were measured on a June 30 fiscal year (for 2003 and 2004), there was simply no time for a "sentinel event." See Testimony of Mr. Sheils, **AR 11, p. 5170 (p. 161, line 14 - p. 162, line 7).**

[7] Dr. Thorpe referenced a "sentinel event" theory in his pre-filed testimony, but did not appear at the hearing and his testimony was not admitted. Therefore, the Chamber believes that it would be improper for the Superintendent to rely on Dr. Thorpe's "sentinel event" theory in reaching his decision.

Finally, if the "critical hypothesis" was supportable, the hospitals would not have recognized similar decreases in cost trend shifts prior to enactment of the Dirigo law in June 2003. Indeed, if hospitals experienced similar decreases in cost trends before Dirigo Health, the fact that it occurred afterward cannot be attributed to Dirigo Health (unless of course it is also assumed that the factors that led to fluctuation have magically disappeared on July 1, 2003). As illustrated above, Maine hospitals experienced significant cost trend shifts before Dirigo Health was enacted -- in fact, cost per CMAD actually decreased from 1999 to 2000. **AR 10, p. 4693.**

(4) The Board's Methodology Willfully Ignores Other Explanations for Decreasing Cost Growth.

Not only does the Board's methodology confuse random, naturally occurring fluctuations with Dirigo-related savings, but it also willfully ignores the most likely explanations for decreased hospital cost growth. For example, the MaineCare program cut rates to hospitals by over $50 million for SFY 2004. **AR 9, p. 4264; 4288; 4314.** If hospitals lose over $50 million in revenue (while still providing the same services), they must cut expenses, increase charges to replace the revenue, or a combination of the two. Although the DHA's witnesses did not dispute the Medicaid payment cuts -- or the likelihood of expense cutting measures in response to payment cuts -- the DHA's methodology assumes that all reductions in cost growth were solely attributable to Dirigo Health. This conclusion disregards any cost cutting measures by hospitals to make up for the lost revenue associated with the MaineCare rate cuts.

The Chamber's witnesses provided substantial and unchallenged evidence that there are various factors that impact a hospital's cost growth. Mr. Mercier and Mr. Sheils explained that many factors go into the fluctuation of CMAD, including Medicaid cuts, changes in payor mix, fluctuations in volume, and employer initiatives (among others). **AR 11, p. 5167 (p. 150, line 20 - p. 152, line 25).** Ms. Levesque, Ms. Bubar and Ms. Kenney provided undisputed testimony regarding the effects of employer initiatives. The DHA's witnesses did not dispute that there are

many factors that influence cost growth. Furthermore, Mr. Schramm admitted that the Mercer Methodology simply measures fluctuations in cost growth, and suggested that it was the Board's responsibility to determine what part of the "savings" identified by the Mercer methodology is related to Dirigo Health (as opposed to other factors). **AR 11, p. 5115 (p. 95, line 9 - p. 96, line 10).**

During its deliberations and in the Board's Determination, the Board made no attempt to parse out these well established factors, and instead concluded that all of the "savings" was attributable to Dirigo Health.

(5) The Chamber Did Not Propose an Alternative Methodology for CMAD.

The Board's Determination incorrectly states that "[t]he Chamber proposed an alternative methodology [for CMAD] through the testimony of Mr. John Sheils and documents admitted into evidence during the hearing." Id. at p. 11. To be clear: the Chamber did not propose an alternative methodology for CMAD, but merely presented Mr. Sheils' testimony and supporting documentation to demonstrate the flaws in the Mercer methodology and to serve as an illustration of why the Mercer CMAD methodology is unreasonable.[8] Indeed, Mr. Sheils made clear during his direct testimony that he was simply using Mercer's own numbers and methodology as proof that the methodology is an unreliable measure of "savings," and that a multi-variate analysis would be necessary to distinguish random fluctuations from Dirigo-related "savings." **AR 11, pp. 5167 (p. 149, line 4 - 10; p. 150, line 20 - p. 152, line 25) .**

The slides presented by Mr. Sheils conclusively prove that:

- Even when measured in the aggregate, the rate of cost growth per CMAD fluctuated significantly from year-to-year;
- The rate of cost growth per CMAD for SFY 2005 (6.9%) exceeded the historical average (6.2%) and median growth rates (4.7%), as well as the 4.5% MHA target;

[8] In fact, the Chamber has been clear from the outset that CMAD should not be counted at all.

- The $72 million of "savings" recommended by Mercer was driven by an anomalous year (2002);
- Adding only one year (1999) to the base period resulted in zero "savings" for SFY 2005;
- Using the median growth rate in the three year base period reduced savings from over $70 million to $14.5 million.

See Chamber Exhibit 21, **AR 10, pp. 4686-4696.**

Furthermore, Mr. Sheils testified that the methodology is unreasonable because the amount of "savings" depends entirely upon "selectivity of data," and because it produced "savings" in a year in which the actual growth rate exceeded all historical measures, and because it produced "savings" before Dirigo Health existed. **AR 11, pp. 5165 - 5170.** Mr. Mercier testified that the methodology was unreasonable because very small changes to volume produce significant changes to "savings." **AR 11, pp. 5151 - 5158.** Again, the slides prepared by Mr. Sheils were designed to illustrate these points, not to affirm the Mercer methodology in any form or present an alternative methodology. **AR 11, p. 5170 (p. 163, line 21 - p. 164, line 9).**

Apparently, after hearing the testimony of Mr. Sheils and Mr. Mercier, the Board realized that the Mercer proposal was unreasonable. However, the Board chose to disregard the full substance of Mr. Sheils' and Mr. Mercier's testimony, and instead selected the one scenario that still produced some degree of "savings." This patently results-oriented process is unreasonable, as the documentation upon which the Board relies (the slide presented by Mr. Sheils) illustrates that methodology itself is fatally flawed. It cannot possibly be used to support the reasonableness of the Board's Determination.

(6) The Board's Methodology Double Counts Savings From SFY 2004.

Another problem with the Board's methodology is that it double counts the savings from SFY 2004. Since the actual growth rate for SFY 2005 (6.9%) exceeded the MHA target (4.5%), the historical median (4.7%), and the inflation adjusted historical average (6.2%), it is difficult to

understand how the application of a brand new target (MHA target) would produce any "savings." **AR 10, p. 4687.**

The general Mercer methodology, adopted by the Board, determines savings by projecting SFY 2005 cost by reference to actual SFY 2003. However, continuing to use SFY 2003 as the baseline for projecting cost disregards the nature of a new yearly voluntary limit. Indeed, since the DHA conceded that the original 3.5% limit not longer applied, the only way to determine whether or not a hospital has complied with the new MHA 4.5% limit would be to compare actual 2005 costs to actual 2004 costs, and then determine the percentage increase. As testified by Mr. Michaud, that was the intent of the MHA target. It was never intended as a measure of Dirigo Health-related "savings." **AR 9, p. 4311.**

(7) Applying the Board's New Methodology to the First Assessment Year Would Result in Significantly Higher "Savings".

At last Fall's hearing, the Superintendent found that Dr. Kane's hospital data supported a finding that there was $33.7 million of CMAD savings for SFY 2004. At this Spring's hearing, Mr. Schramm testified that Mercer again used Dr. Kane's data, without material revision, as the basis for its calculations for all years except 2005. **AR 11, p. 5116 (p. 99, line 2 - 14).** If, as Mr. Schramm testified, Mercer used the exact same data reviewed by the Superintendent, and simply aggregated it on a statewide basis, it would stand to reason that the new methodology would produce a result very similar to that deemed reasonable by the Superintendent. Indeed, Mr. Schramm admitted this himself. **AR 11, p. 5116 (p. 99, line 15-21)** ("If you were to use the exact same methodology and data sources and only correct for the data errors, the change would not be substantial").

However, that is not the case. Applying the new Mercer methodology, SFY 2004 savings would have been $76.9 million (compared to the $33.7 million deemed reasonable by the Superintendent). **AR 10, p. 4689.** According to Dr. Kane's COM calculations, total SFY 2004

operating income for all Maine hospitals was approximately $74 million. **AR 9, p. 4266 - 4269.** A methodology that produces more than twice the "savings" deemed reasonable by the Superintendent cannot be found to be reasonable. Moreover, a methodology that produces "savings" that exceeds total operating income for the same hospitals is clearly defective. And while the Board's adoption of a median (as opposed to average) historical growth rate makes a fatally flawed method only slightly less flawed, it plainly does not go far enough. Indeed, applying the Board's methodology to SFY 2004 would result in $54.9 million of "savings." **AR 10, p. 4693.** Again, this figure significantly exceeds the amount deemed reasonable by the Superintendent, and represents a substantial majority of the hospitals' total operating income. This is ample proof that even the Board's methodology is unreasonable.

(8) The Board's Methodology Improperly Assumes that All Savings Should Form the Basis of an SOP.

If the CMAD "savings" is approved by the Superintendent, the Board will once again include this amount in the SOP. In the event that the health insurance carriers subject to the SOP have not realized the exact same amount of savings through reduced charges from hospitals, these carriers will be forced to pass the SOP on to consumers in the form of higher insurance rates.

There are two fundamental problems with the Board's methodology in this respect. First, since the Board determined CMAD "savings" by reference to aggregated hospital data, it will be impossible for a carrier to know where to go to negotiate lower charges.

Second, the Board failed to parse out the "savings" that are properly attributable to Dirigo Health, and therefore should be recovered by health insurance carriers subject to the SOP. However, any true cost savings would properly accrue to all health care payors, including MaineCare, Medicare and self-pay. Thus, the Board's CMAD methodology is flawed and

invalid because it assumes that all of the savings have (or will) accrued to, and be recoverable by, commercial health carriers and self-funded employer plans, when that is clearly not possible.

For example, it is undisputed that the health insurance carriers subject to the SOP represent less than half of hospital utilization in Maine. See Testimony of Steven Michaud, **AR 9, p. 4313, line 9-14.** Therefore, these health insurance carriers should (at best) benefit from cost savings in proportion to their utilization of services. Furthermore, fourteen (14) of the thirty-six (36) measured hospitals are critical access hospitals ("CAH"). A CAH is reimbursed on a reasonable cost basis for both Medicare and Medicaid services. **AR 11, p. 5105 (p. 53, line 10 - p. 54, line 10); AR 10, pp. 4679-4680.** Additionally, Medicaid outpatient services at non-CAH hospitals are also reimbursed on a reasonable cost basis. **Id.** Accordingly, as Mr. Brauner conceded, any reduction in cost is automatically passed along to the Medicare and Medicaid programs. **AR 11, p. 5105 (p. 53, line 10 - p. 54, line 10).** Since Medicare and Medicaid patients typically represent approximately 60% of hospital inpatient and outpatient utilization **(AR 11, p. 5147 (p. 70, line 18 - p. 71, line 1)**, a substantial share of these cost "savings" would not be available to reduce rates to commercial health carriers and self-funded employer plans, and cannot be recoverable by those entities.

Finally, a reduction in hospital costs generally does not benefit commercial health carriers because most pay hospitals on the basis of a discount off charges or a per diem. There was undisputed testimony that lower costs, standing alone, may not allow a hospital to reduce its charges to commercial health carriers. See Pre-Filed Testimony of Mr. Mercier and Mr. Michaud. The DHA provided no evidence that the hospitals did -- or even could -- reduce their charges based upon the "savings" methodology. Since there was no dispute that MaineCare cut hospital payment rates by over $50 million dollars for SFY 2004, and the effect of these cuts continued through SFY 2005, it is clear that the hospitals were forced to cut expenses to make up

for the lost MaineCare revenue, and were in no position to pass along these so-called "savings" to commercial payors. In light of these undisputed facts, reductions in the rate of cost growth cannot be attributed solely to a voluntary cost limit (whether Dirigo-related or not).

(9) The Mercer Methodology Improperly Offset the Hospital Tax.

Although the so-called Hospital Tax is a binding, legal obligation of the hospitals, the Mercer CMAD methodology pretends as though the hospitals do not incur this expense. Because the Mercer CMAD methodology removes this cost from its analysis, it artificially lowers each the hospitals' cost per CMAD, and results in a dollar-for-dollar increase in "savings."[9] Even assuming that the full amount of the tax is not a true "cost" because the hospitals receive enhanced MaineCare payments as a result of the tax, there is undisputed evidence that the hospitals pay more in tax than they recover in enhanced Medicaid payments. **AR 11, p. 5145 (p. 52, line 4 - 7); AR 9, 4053 - 4056.** Accordingly, approximately $5 million dollars of cost should be added to the 2005 CMAD calculation, resulting in a reduction of "savings" of a similar amount.

B. Uninsured Savings Initiatives.

Pursuant to the Dirigo legislation, Dirigo Health is directed to measure savings related to any reduction or avoidance of bad debt and charity care costs ("BD/CC") to health care providers as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1). The Board adopted in full Mercer's proposed methodology for three separate Uninsured Savings Initiatives: (1) Reductions to BD/CC; (2) MaineCare Adult Expansion; and (3) Woodwork Effect. The Board's methodology for each initiative is highly theoretical, with multiple unsupported assumptions that are contradicted by the DHA's own data. Furthermore, despite the ready

[9] Simply by replacing the $48 million offset with $0 and re-calculating Mercer's spreadsheet, "savings" drops by the exact amount of the tax so removed.

availability of data from reliable (governmental) sources to measure what actually happened to BD/CC costs, the Board's methodology failed to compare its results to the reported uncompensated care data for providers to measure or confirm their assumption that uncompensated care costs were reduced. As discussed below, employing a highly theoretical method without any analysis of available data on what actually happened is unreasonable.

(1) Reductions in Uninsured BD/CC.

This initiative attempts to quantify the "savings" related to Dirigo Choice members who were previously uninsured or underinsured by identifying: (a) the amount of BD/CC for hospitals and other providers; (b) isolating the amount of BD/CC attributable uninsured or underinsured; and (c) reducing these projections to a per member per month amount. In developing this methodology, Mercer relied upon several key assumptions for which it provided no documentary support and/or disregarded readily available documentation. Two things became clear at the hearing: First, Mercer's assumptions are generally not supported by documentation, and in many cases they disregarded readily available documentation that was contrary to its assumptions. See Cross-examination of Mr. Russell by Mr. Stiles ("Russell Cross") **AR 11, pp. 4981-4991.** Second, Mercer used very aggressive assumptions. **Id.** A discussion of these assumptions and their flaws follows:

Mercer Assumption: 50% of BD is attributable the uninsured.

Flaw: According to Mr. Russell, the DHA's principal witness for the Uninsured Initiatives, Mercer relied upon a report by Dr. Kane when estimating total BD/CC. **AR 11, p. 4981; AR 8, pp. 3637-3650.** Although this report states that 46% of BD/CC for 2003[10] is related to self pay patients, and Mercer did no independent analysis of this issue, Mercer "rounded up"

[10] For 2003, the base period used for Mercer's calculations, Dr. Kane's research showed that Medicare patient were responsible for 18% of BD, Medicaid patients 4%, Privately insured 32%, and Self Pay 46%. **AR 8, p. 3646.** Again, however, her report goes on to say stated that the privately insured category was likely understated and the self pay overstated. **Id.**

to 50% for its assumption. This aggressive and unsupported assumption overstated "savings" by more than $100,000.

Furthermore, Dr. Kane's report shows that even she believed that the 46% self-pay figure was aggressive. Her report states that "privately insureds are responsible for at least 30%, and probably more when co-payments and deductibles that may be in the self-pay category are taken into account." **AR 8, p. 3646.**

Conclusion: Because Mercer relied substantially upon Dr. Kane's report for its BD/CC analysis and offered no separate analysis or documentation to support its assumption, the aggressive 50% figure must be rejected.

Mercer Assumption: 90% of CC is attributable to the uninsured.

Flaw: Mercer provided no support for this aggressive assumption. Dr. Kane's report shows that 21 of Maine's hospitals had a charity care policy that applied to patients with incomes between 100% and 200% of the FPL, with one applying up to 300% of the FPL. **AR 8, pp. 3641-3642.** Furthermore, the Muskie Institute surveys available to Mercer showed that many Dirigo Choice members with incomes below 200% of FPL had insurance prior to enrolling in Dirigo Choice. **AR 8, pp. 3666, 3671, 3695, 3704.** Therefore, the evidence in the record shows that patients who had insurance could have qualified for CC for out of pocket expenses such as copayments and deductibles. However, Mercer declined to analyze the readily available documentation and provide a supportable assumption.

Conclusion: Since Mercer had available information describing hospital charity care policies, and these policies are not limited to uninsured (but rather apply to patients based upon income levels), the aggressive 90% assumption must be rejected.

Mercer Assumption: BD/CC increased by 9.2% trend factor.

Flaw: Mercer provided no documentary support for its assumption. Dr. Kane's report shows that BD/CC actually decreased by $10 million from 2002 to 2003. **AR 8, p. 3643.** Therefore, it is unclear why Mercer artificially inflated the BD/CC. Furthermore, Mercer could have obtained more current BD/CC information for 2004 and 2005 from public sources or from hospitals, just as Dr. Kane did. However, Mercer declined to collect such information and use it in its analysis. See Russell Cross. Instead, it adopted an aggressive assumption that finds no foundation in actual data.

Conclusion: Since Mercer declined to collect and use more current data, and because its assumption is contradicted by Dr. Kane's Report, the aggressive 9.2% assumption must be rejected.

Mercer Assumption: 4.2% adjustment for cost sharing.

Flaw: Mercer provided no documentary support for this assumption. Although Mercer used actual claims data to identify the total possible cost sharing obligations for Dirigo Choice members, it simply assumed that only 20% of this amount would go unpaid by Dirigo Choice member. **AR 8, p. 3636.** Interestingly, Mercer did not undertake any analysis to determine the appropriateness of this assumption, even though there was sufficient available information to do so. For example, Mercer and the DHA had information regarding each member's financial status and on-going cost sharing obligations. See Russell Cross, **AR 11, pp. 4981-4991**. Finally, this low estimate (which reduces savings) stands in stark contrast to the aggressive assumptions designed to inflate savings.

Conclusion: Since Mercer declined to provide a supportable analysis, the 4.2% adjustment for cost sharing should be substantially increased.

Mercer Assumption: 39% of Dirigo Choice members were previously uninsured.

Flaw: Mercer's assumption was based solely upon the most recent enrollees, which admittedly represent a very small portion of actual membership. **AR 8, 3633; AR 11, p. 4983 (p. 41, line 16-18).** By overstating the percentage of previously uninsured, Mercer artificially inflated "savings." **AR 11, p. 4983 (p. 42, line 16-18).** Mercer declined without explanation to incorporate data from the Muskie Surveys, which shows that the percentage of uninsured patients was substantially lower. **AR 8, p. 3671-3673.**

Conclusion: Because the assumption was not based upon the actual data from the Muskie Surveys, the 39% assumption must be rejected.

Mercer Assumption: Saving should be inflated by 36.2% based upon Mercer's claims probability distribution ("CPD").

Flaw: The Mercer CPD assumes that Dirigo Choice members were "the people who used higher than average amounts of medical care when they were uninsured." **AR 11, p. 4985-4986.** Mercer provided no specific, Dirigo-based documentary support for this aggressive assumption, and in fact ignored available data that would disprove the assumption. For example, the Muskie Surveys tracked prior health care utilization of previously insured member, and concluded that persons with higher deductibles where more likely to report an unmet health care need. **AR 8, pp. 3671-3673.** However, Mercer assumes just the opposite for the previously uninsured Dirigo Choice member -- that uninsured persons would have been less likely to have an unmet health care need. Furthermore, Mr. Russell testified that his assumption was based on the belief that "the first people in the Dirigo door were not average. They were, in fact, higher than average utilizers of bad debt, or services that became bad debt and/or charity care." **AR 11, p. 4986 (p. 55, line 1-7).** Although Mercer provided no evidence that the early enrollees were <u>in fact</u> higher than average utilizers, Mercer applied this aggressive assumption to <u>all</u> Dirigo Choice enrollees -- not just the "first in the door." It certainly cannot be that <u>only</u> Dirigo Choice

enrollees were above average utilizers, while all other uninsured persons are 36% below average utilizers. Mercer certainly did not attempt to verify this conclusion by showing a proportionally high drop in actual BD/CC during the first Dirigo year. Furthermore, if the Dirigo Choice enrollees were indeed higher utilizers of services, Dirigo Choice claims paid during 2005 should have been 36% higher than insured persons under other insurance programs. However, neither Mercer nor the DHA produced such evidence to support this aggressive assumption that merely inflates "savings."

Conclusion: Because Mercer provided no evidence to support its assumption, the aggressive 36% increase to savings should be rejected.

Finally, Mercer's methodology double counts the savings from the first assessment year (2005). Mercer isolated the BD attributable to uninsured patients for 2006. Because the 2005 Dirigo Choice enrollees (as well as Adult Expansion) had insurance at the outset of 2006, that could not possibly contribute to uninsured BD. Further, any savings attributable to 2005 was already counted in the first assessment year.

(2) Reductions to Underinsured BD/CC.

Mercer applied many of the same assumptions addressed above. In addition to the flaws identified in the previous section, Mercer's Underinsured calculation contains additional assumptions that lack evidentiary support, contradict Mercer's source data, and are otherwise unreasonable.

Mercer Asssumption: 20% of BD is related to underinsured.

Flaw: In developing its BD/CC calculations, Mercer relied upon Dr. Kane's report. Dr. Kane concluded, based upon a survey of Maine hospitals, that the breakdown of BD by payer status was:

Medicare:	18%
Medicaid:	4%

Privately Insured: 32%
Self-Pay: 46%

AR 8, p. 3646. As previously explained, Dr. Kane acknowledged that the percentage attributable to privately insured was likely higher due to a tendency of hospitals to report co-pays and deductibles as self-pay. **Id.** Mr. Russell admitted during cross-examination that Mercer had no support for its 20% assumption. **AR 11, p. 4988 (p. 61, line 8-11).** In light of Dr. Kane's report and Mercer's other assumptions, the numbers just do not add up. Indeed, Mercer assumes that 50% of BD is attributable to uninsured and 20% is related to underinsured. Since Medicare and Medicaid make up at least 22%, this leaves only 8% of BD for privately insured patients who do not meet Mercer's definition of underinsured. This unsupported assumption is inconsistent with the undisputed testimony of Mr. Sheils, who explained that 31% of BD relates to patients who are over 300% of the FPL (and thus do not fall within the definition of underinsured[11]). **AR 8, pp. 3858; 3883.** Furthermore, the assumption contradicts the results of the Muskie Surveys which found that low income patients with high deductibles were most likely to have an unmet health care need. If these patients are the most likely to have an unmet health care need, they must be less likely to seek care and thereby contribute to BD.

Conclusion: Mercer's aggressive 20% assumption should be rejected.

Mercer Assumption: 25% of Dirigo Choice enrollees were previously underinsured.

Flaw: Again, Mercer offered no evidentiary support for this assumption. **AR 11, pp. 4988-4989 (p. 61, line 19 - p. 65, line 12).** However, Mercer acknowledged that all of the information necessary to make such a calculation was collected by the DHA either through the application process or the Muskie Survey. **Id.** Indeed, the DHA must collect financial information to determine eligibility for subsidies, and it must collect prior coverage information.

[11] Mr. Russell testified that Chamber Exhibit 1, tab 5 contained the definition of underinsured used by Mercer. **AR 8, pp. 3651-3655.** This includes only persons (1) with income below 200 percent of the FPL who have a deductible that meets or exceeds 5% of income; or (2) persons with income between 200 and 299 of the FPL who have a deductible that meets or exceeds 10% of income.

Id. Notwithstanding the availability of this information, Mercer declined to determine the exact number of previously underinsured members. More importantly, Mercer declined to determine the number of Dirigo Choice members who would continue to meet the definition of underinsured given the substantial deductibles and potential out-of-pocket expenses associated with Dirigo Choice. **Id.** Furthermore, Mercer declined to take into account the substantial number of previously insured member who had lower deductibles before switching to Dirigo Choice. **Id.** In other words, Mercer ignored the readily available information that would produce an exact number and instead adopted another aggressive assumption that inflates "savings."

Conclusion: Mercer's aggressive 25% assumption should be rejected as unreasonable.

Mercer Assumption: Saving should be inflated by 18.1% based upon Mercer's CPD.

Flaw: The Mercer CPD assumes that Dirigo Choice members were higher than average utilizers of medical care while they were underinsured. Again, Mercer provided no specific, Dirigo-based documentary support for this aggressive assumption, and in fact ignored available data that would disprove it. For example, the Muskie Surveys tracked prior health care utilization of previously insured member, and concluded that persons with higher deductibles where more likely to report an unmet health care need. **AR 8, pp. 3671-3672.** However, these are the exact same people that Mercer now assumes would have been more likely to utilize medical care in the past.

Conclusion: Mercer's aggressive 18.1% increase to savings should be rejected.

(3) MaineCare Adult Expansion.

Mercer applied the same unsupported assumptions identified above when determining the PMPM amount for MaineCare Adult Expansion. In addition to these flaws, Mercer improperly assumed (without any evidence or analysis) that all new MaineCare members were previously

uninsured. **AR 11, pp. 4990-4991 (p. 69, line 4 - p. 73, line 3).** During cross examination, Mr. Russell acknowledged several key facts with regard to the inappropriateness of this assumption. First, he conceded that Mercer's literature search confirmed the existence of the "crowd out" effect, in which Medicaid expansions often result in people dropping private insurance in favor of free Medicaid coverage. **Id.** Notwithstanding clear knowledge of the "crowd out" phenomenon, Mercer made no downward adjustment to "savings." **Id.** Second, Mercer made no attempt to verify whether or not these new MaineCare members were previously insured, although Mr. Russell conceded that the results of the Muskie Survey would indicate that it would not be unusual for a person at 200% percent of the FPL to be insured. **Id.** Third, under cross-examination by Mr. Roach, Mr. Russell testified that the number of uninsured has remained relatively stable over the years, but declined slightly from 2002 to 2004. He also conceded that, at the same time, the number of previously commercially insured individuals has declined. **AR 11, p. 4996 (p. 95, line 3 - p. 96, line 10).** These two facts, taken together, show that it is likely that the MaineCare expansion has drawn a number of enrollees that were previously insured. Again, however, Mercer admittedly made no adjustment for this "crowd out." Since the Board carries the burden of proving the reasonableness of this assumption, the Superintendent should reject any savings related to the MaineCare Adult Expansion.

(4) Woodwork Effect.

Mercer recommended, and the Board adopted, savings related to the Woodwork Effect. The savings consisted of reductions to BD attributable to persons who applied for Dirigo Choice, but were determined to be eligible for MaineCare. However, Mercer assumed, without verification, that all such persons were previously uninsured. Since Dirigo Choice is required to collect information regarding previous health insurance coverage, this information was readily

available. Since the record contains no proof that these individuals were, in fact, previously uninsured, the Superintendent must reject any savings related to the Woodwork Effect.

(5) Summary.

The Mercer methodology adopted by the Board improperly assumes that "savings" may be reasonably predicted using a theoretical model that does not reflect actual reduction to BD/CC growth. Mercer applied this theoretical approach in the first assessment year, apparently because there was not a year's worth of actual data available. Now that this data is available, Mercer's approach should be rejected as unreasonable. As demonstrated by Mr. Sheils' BD/CC exhibit, if Mercer applied the same methodology for BD/CC as it used for CMAD (projecting 2005 bad debt using historical averages), there would be no savings for the Uninsured Initiatives because actual 2005 BD exceeded the historical projection. **AR 10, p. 4695.**

Since Mercer provided no support for its aggressive assumptions, and because the use of actual data disproves the reliability of Mercer's theoretical approach, all Uninsured Initiative "savings" should be rejected as unreasonable.

C. CON and CIF Savings Initiatives.

As explained above, Mercer's supplemental report purports to calculate CON/CIF savings by reference to two separate theories, resulting in the CON Savings Methodology and the CIF Savings Methodology. Even assuming CON/CIF is an appropriate savings initiative, Mercer's methodology, which the Board adopted wholesale, is unreasonable and should be rejected by the Superintendent for at least the following reasons:

First, the CON/CIF methodology attempts to capture future savings rather than current, achieved savings. See Testimony of Steven P. Schramm **AR 11, p. 5047 (p. 297, lines 1-8)**; see also Mercer supplemental report, **AR 3, pp. 1460-1461** (reducing expected third year operating cost savings to present value from as far into the future as 2010). This violates a fundamental

principle of savings--that the savings must actually be realized and achieved. See Handout from the Governor's Office of Health Policy and Finance dated June 11, 2003, **AR 10, p. 4750** (stating: Capture realized savings from the reduction in bad debt and charity care through savings offset payment.); see also Superintendent's Decision and Order for the First Assessment Year at page 16 (rejecting, for example, the inclusion of alleged savings related to future increased PIP payments because "[t]he savings offset payments will be levied during CY 2006 and should correspond to savings that have already been achieved and measured." (emphasis added)). This fundamental principle makes sense because the alternative of counting future savings in the current Dirigo year does not reasonably permit the market to recapture savings through price negotiations. Counting future savings now also runs contrary to Mercer's guiding principles, [12] and results in private payers paying a tax to fund Dirigo Health and a MaineCare expansion, not a payment to offset actual savings.

Second, Mr. Schramm admitted that CON savings will be included in CMAD savings in future years. See Testimony of Steven P. Schramm **AR 11, p. 5047 (p. 297, lines 9-13)**; Testimony of Steven Michaud, **AR 9, pp. 4313-4314**; Testimony of Catherine Cobb, **AR 11, pp. p. 5039 (p. 265, lines 8-25).** Although Mr. Schramm suggested Mercer would make an adjustment to CMAD in the future to account for this problem, this only serves to illustrate that it

[12] Mercer's guiding principles are, in relevant part, as follows:

- Initiatives are primarily voluntary. It is the role of the marketplace to voluntarily comply with savings targets and to recapture savings in price negotiations.
- The savings, once calculated, should not be overstated, nor should they be understated: the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system.
- When calculated, the savings will be used to sustain DirigoChoice at no additional costs.

Testimony of Steven P. Schramm, **AR 3, pp. 1051-1052, line 99 through** (Emphasis added). Taken together, the Chamber interprets these three guiding principles to mean that it is (1) incumbent upon the market to recapture savings in price negotiations, so (2) the savings and resultant SOP will sustain Dirigo Health at no additional costs, and (3) the savings methodology must be reasonable to support and facilitate both (1) and (2). That is, the methodology must calculate savings in a manner that reasonably permits the market to recapture savings through price negotiations, so Dirigo Health may be sustained at no additional costs to private payers; otherwise, the guiding principles are not met and private payers must pay a tax to fund Dirigo Health and a MaineCare expansion.

is simply not reasonable to count future savings now, especially when Mercer's CMAD methodology will account for it if the alleged savings are actually achieved. The Superintendent should reject as unreasonable any methodology that will necessarily result in double-counting now or in the future.

Third, all payers would utilize the services represented by the CON submissions reviewed by Mercer. Thus, it only makes sense that all payers should realize their respective share of "savings." Stated another way, given that commercial payers subject to the SOP represent less than half of hospital utilization, and if CON/CIF savings are included, then they should be reduced by 60% because commercial payers cannot recapture savings which accrue to public payers.

Based on the foregoing, Mercer's methodology for calculating purported savings related to CON/CIF should be rejected as unreasonable.

D. Health Care Provider Fee Initiatives.

Dirigo Health once again calculated "savings" relating to the Maine Department of Health and Human Services' decision to (1) pay hospitals what they are owed for treating MaineCare patients and (2) award a long-awaited increase to the MaineCare physician fee schedule. As explained below, Mercer's methodology is not reasonable.

(1) PIP Payments

With regard to the future increase in PIP payments, there is nothing to support the blind assumption that increases in payments--which hospitals have already booked as receivables--will actually result in savings. The gist of Mr. Geoffrey Greene's testimony was that he heard that some hospitals may have some costs associated with low MaineCare PIP payments and late

MaineCare settlements.[13] See Testimony of Geoffrey Green, **AR 11, p. 5055 (p. 330, lines 1-8).** However, there was no competent evidence establishing that any hospital experienced increased costs by carrying MaineCare settlement receivables, and as a result no evidence that this initiative actually reduced any hospital's costs. The assertion that paying hospitals a booked receivable will save over $7 million dollars, without any evidence of actual costs associated with the receivable, does not pass the straight face test.

Likewise, there is no competent evidence to support Mercer's assumption that PIP increases support a time value of money calculation using three years, and no adjustment made for the fact that PIPs are paid out over 52 weeks. Instead, the methodology assumes PIP is a single payment event, with a three year lag between the end of PIP and settlement with MaineCare. These are not reasonable assumptions. There are only a few hospitals with a three year lag time between the end of PIP and settlement. Most settlements are completed within 18 months after the end of PIP. Thus, a reasonable assumption would have used a 2 year lag time at most.

Similar to CON/CIF, this initiative seeks to measure future savings resulting from PIP increases that have not actually occurred yet. In fact, there is no evidence in the record that the PIP increases will actually occur. Dirigo Health did not offer a budget figure from DHHS, and did not offer any PIP letters demonstrating actual PIP increases. See Testimony of Geoffrey Green, **AR 11, p. 5052 (p. 318, lines 18-25 through p. 319, line 1).** A methodology which measures future alleged savings (as compared to realized and achieved savings), and which relies on future PIP increases that have not been established by competent evidence is unreasonable and should be rejected.

[13] It strikes the Chamber as odd that the State may create costs (assuming costs are actually created) through low and untimely MaineCare payments on the one hand, then on the other, finally begin to adhere to what the MaineCare regulations arguably require by making reasonable PIP projections, then use the projections as a basis for an assessment that hospitals and others will have to pay by providing insurance to their employees.

Finally, although Mercer characterizes all of its calculations as conservative, a closer look does not bear this out. With the hospital fee initiative, Mercer calculates the SFY 2006 PIP increase by taking the difference between the SFY 2006 and SFY 2005 PIP levels. Mercer then calculates the SFY 2006 PIP increase, but instead of taking the difference between SFY 2007 and SFY 2006, Mercer double counts by comparing SFY 2007 to SFY 2005. This is unreasonable and should be rejected.

(2) Physician Fee Increase

With respect to the physician fee initiative, Maine physicians had not received a fee increase from MaineCare in almost 20 years. As a result of this longstanding underpayment, many Maine physicians limit the number of MaineCare patients they see, or refuse to see them altogether. This began to cause access problems for MaineCare members. **AR 8, p. 3948.** Recognizing this problem, the Hospital Commission advocated for the long overdue fee increase "because doctors cannot afford to service the individuals [Medicaid patients]." **Id.** Therefore, the basis for increasing the MaineCare physician fee schedule is decreased physician participation causing concerns with MaineCare member access--not as a result of Dirigo Health.

What is worse, Dirigo Health's methodology unreasonably assumes that the MaineCare physician fee schedule increase will reduce cost shifting because the physicians will automatically pass through the entire, long overdue, MaineCare fee increase to commercial payors. However, there is no evidence in the Dirigo Filing or elsewhere in the Administrative Record to support that such a reduction of cost shifting has actually occurred -- or even could occur. First, simply providing additional revenue does not necessarily result in savings. See Testimony of Commissioner Wyke, **AR 11, p. 5010 (p. 149, lines 13-15).** Second, as explained by Anthem's witness Ms. Roberts, Medicare, Medicaid and most commercial payers make payments to physicians based upon a fixed fee schedule, and therefore a reduction to a

physician's charges would not have the effect assumed by Dirigo Health and Mercer. See Testimony of Sharon Roberts. **AR 11, p. 5098 (p. 26 through p. 28).** Indeed, Ms. Roberts testified that Mercer's methodology would require insurers to create two separate fee schedules, which is entirely unworkable. **Id.** Finally, shouldn't the physicians be permitted to keep these long-overdue payment increases? Requiring the physicians to immediately turn over the increase to insurance carriers in the form of lower reimbursement makes no sense in law or logic, and runs contrary to the goal of maintaining patient access--yet that is the result of including the physician fee increase as savings

Based on the foregoing, Mercer's methodology for calculating purported savings related to hospital and physician fees should be rejected as unreasonable.

V. CONCLUSION

Dirigo Health's Proposed Year 2 Methodology is unreasonable and must be rejected because: (1) it includes matters not related to Dirigo Health; (2) it includes flawed methodologies that do not distinguish between naturally occurring fluctuation in CMAD; and (3) it relies upon unsupported and unsupportable assumptions.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I, William H. Stiles, attorney for the Maine State Chamber of Commerce, hereby certify that on this day the foregoing document was served on the following parties via first-class mail and electronic mail:

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